

THE AFFORDABILITY OF COVERAGE FOR HIGH-COST INDIVIDUALS: OPTIONS FOR WASHINGTON STATE

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by

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Introduction

Like Washington, many states regulate health insurance rates to help ensure that coverage is available to individuals who may need significant amounts of health care, as well as individuals likely to use very little care. When health insurance rates are constrained to make coverage more affordable to high-risk individuals, insurers are forced to manage risk that they otherwise would avoid by denying coverage or charging much higher premiums. But even when required to issue coverage and compress health insurance rates, insurers still may attempt to manage risk via benefit design—making adequate benefits for individuals and groups with high health care needs more difficult to find and afford.

Small insurers may find it especially difficult to survive in a market where rating is constrained or other regulation forces them to make comprehensive coverage widely available. With a relatively small base of business over which to spread risk, small insurers have a particularly strong incentive to avoid risk and can set the standard for competition across the entire market—reducing the availability of coverage for some high-cost health care needs.

To support regulation intended to make insurance accessible and affordable for high- and low-risk residents alike, many states operate high risk pools (intended to support access in the individual market); reinsurance programs (which may serve either or both the individual and small group markets); and/or risk adjustment programs (which also may serve either or both markets). Washington permits insurers to deny coverage to individual applicants, and since 1988 has operated the Washington State Health Insurance Pool (WSHIP) for residents who are denied coverage. Per federal law, Washington requires small-group carriers to issue coverage to all applicants, and in addition constrains the rates that insurers may charge. However, Washington has no program to support small-group insurers that can draw very different risk and experience very different levels of medical cost in any given year.

Various states have used either or both reinsurance or risk adjustment to support markets that are regulated to improve access to adequate coverage for high-risk residents. In general, reinsurance can help to equalize experience across insurers and, therefore, stabilize health insurance rates. By limiting the losses of insurers that happen to enroll high-risk individuals, reinsurance offers the potential for a more stable market—that is, a market where insurers have less incentive to avoid risk, helping individuals with health problems to access adequate coverage more easily. Such programs also can help relatively small insurers remain in the market when they are otherwise especially vulnerable to adverse selection.

A number of states have developed reinsurance programs for small-group insurers, individual insurers, or both. For example, Connecticut operates a small-group reinsurance program that is the oldest and among the largest state reinsurance programs. New York State operates a subsidized reinsurance program for carriers that participate in Healthy New York, a program intended to make coverage more affordable for low-wage employers and low-income working individuals. In principal, a state could merge its small group and individual markets, and develop a single reinsurance program that would serve both; but in practice this has not yet been done. The one state that has merged its individual and small-group markets—Massachusetts—currently is exploring whether reinsurance will be needed, given

the broad and stable purchase of insurance coverage that is expected under the state's mandate that every individual be insured.

The purpose of this paper is to explain the purpose and use of reinsurance, how reinsurance may compare with other market support strategies that states have used, and how reinsurance might be structured. The paper was commissioned to respond to the recommendation of the Blue Ribbon Commission on Health Care Costs and Access that the creation of a reinsurance program be explored to replace WSHIP. In consultation with the Office of the Insurance Commissioner, it was decided that the paper should broadly explore not only the pros and cons of reinsurance programs, but also other ideas for offering affordable coverage to high-cost individuals under consideration by the legislature—risk adjustment, other types of high risk pools, and the potential of a combined individual and small group market. The paper concludes with a discussion of implications for Washington State and recommendations for further study.¹

Reinsurance

Reinsurance is one of several strategies that state policymakers may consider for helping to make individual insurance more available and affordable. Essentially, reinsurance is stop-loss coverage for insurers. Insurers purchase reinsurance to protect themselves from the risk of large losses. A number of states operate reinsurance programs; the goals and general operation of these programs are described below.

The Goals of Reinsurance

In general, reinsurance is intended to address the fact that relatively few insured individuals are likely to need extensive health care, and therefore incur very high medical cost, at any point in time. In fact, a very small proportion of the population uses the vast majority of health care in any one year. An analysis of expenditures in 1996 concluded that the highest-cost 1 percent of the population accounted for at least 25 percent of total health care expenditures, while the bottom half of all spenders accounted for just 3 percent.² A subsequent analysis of 1998-2000 expenditures among the population under age 65 concluded that the costliest 1 percent accounted for about a quarter of total expenditures, the costliest 2 percent accounted for a third, and the top 5 percent accounted for half.³ Large pools of insured lives demonstrate essentially the same risk distribution as the population as a whole, but small pools (such as a small insurer may experience) may have a very different distribution of risk, positive or negative—due simply to “the luck of the draw” if not also to more or less effective risk avoidance.

While this distribution of high- and low-cost individuals is remarkably consistent from year to year, most high-cost individuals in a given year are no longer

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² M. Berk and A. Monheit. 2001. The Concentration of Health Care Expenditures, Revisited. *Health Affairs* 20: 2004-213.

³ L. Blumberg and J. Holahan. 2004. Government as Reinsurer: Potential Impacts on Public and Private Spending. *Inquiry* 41: 130-143.

high-cost the following year, either because they die or their health improves.⁴ However, because a sizeable minority (30 to 45 percent) remains high-cost in the subsequent year, the incentive is very strong for insurers to rate or design benefits to avoid risk—especially when continuity of coverage at renewal is guaranteed.

In the broadest terms, the principal goal of reinsurance is to refinance the cost of the small proportion of high-cost individuals who account for a significant percentage of the total medical cost of the pool. It is intended especially to help smaller insurers (that spread risk among relatively few insured lives) manage their financial exposure when they happen to enroll an individual or small group with extraordinarily costly medical needs. In this way, it may support competition by helping insurers remain in the market.

However, whether reinsurance—or any other strategy, including relief from regulation—would result in reputable insurers entering the market is unclear. Large insurers have responded to the development of a significant new market—such as Medicare Advantage—and strong financial supports to minimize the risk of entering a new market. In 2005, some large national companies entered states where they had not done business in order to bid on Medicare Advantage business. However, it is unclear whether these insurers would have ventured into these states in the same way in the absence of both the availability of significant new business and substantial financial incentives offered in law. More typically, insurers enter a state by acquiring one or more existing insurers, so that the number of insurers in the market remains the same or declines.

By limiting the downside exposure of accepting a new enrollee, conventional (unsubsidized) reinsurance is intended to have either of two effects: (1) reduced insurer need for very high reserves, thereby potentially reducing premiums, or (2) reduced insurer need for rating and benefit design to avoid risk, thereby improving access to adequate coverage for small groups and individuals with health problems.

By comparison, subsidized reinsurance generally is intended both to directly reduce primary insurance premiums (by providing free or inexpensive reinsurance) and also to support insurers that are obligated to offer insurance to high-risk groups and individuals, and also to constrain the rates they offer. The results of the analysis of 1998-2000 expenditure data cited above⁵ suggest that refinancing the costs of the highest-cost 3 percent of insured lives with public financing (removing their medical costs from the calculation of premiums) could reduce average premiums by one-third—and increase the voluntary purchase of private insurance. The funds needed for such a subsidy, of course, would equal the refinanced amount—one-third of total medical cost.

How Does Reinsurance Work?

Reinsurance is an arrangement between a primary insurer (the insurer that sells coverage to the public) and a reinsurer—either a commercial insurance company or a quasi-public or public agency. Primary insurers purchase reinsurance for individuals or groups that they have agreed to cover. A primary insurer buys reinsurance to reduce its financial exposure for paying these individuals' medical claims. In

⁴ A. Monheit. 2003. Persistence in Health Expenditures in the Short Run: Prevalence and Consequences. *Medical Care* 41 Supplement: III53-III54.

⁵ L. Blumberg and J. Holahan, *Ibid.*

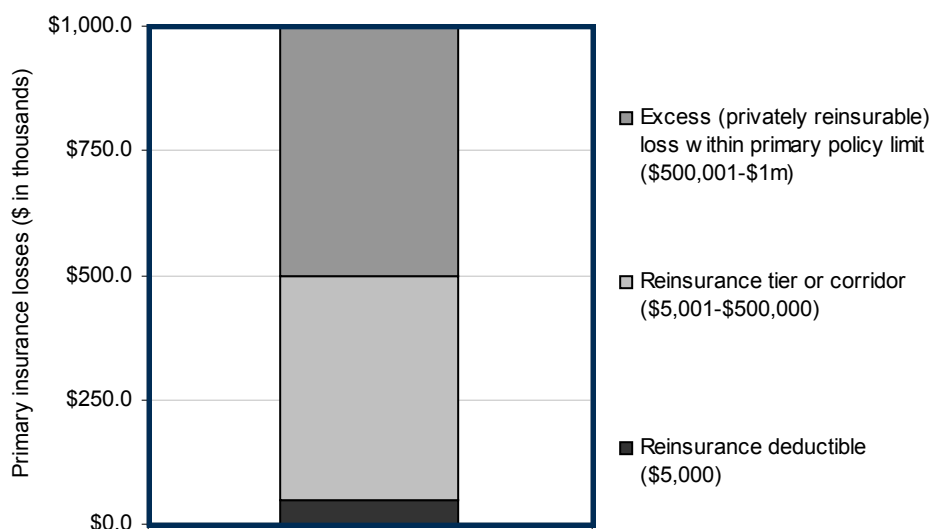
most such arrangements, the reinsured individuals or groups are unaware of the reinsurance arrangement: their contract remains with the primary insurer, and they have no contact with the reinsurer.

A reinsurance contract typically covers a percentage of the primary insurer's claims expense for each reinsured life, but not all. For example, the primary insurer may have a reinsurance contract that covers 90 percent of covered medical cost. By retaining some risk for reinsured lives, the primary insurer also retains an incentive to manage its medical costs effectively.

Reinsurance is commonly sold in “tiers” (or corridors)—that is, the dollar amount that triggers the reinsurance payment (called an attachment point or threshold) is set above an initial level of medical claims and there may be an upper limit on the total amount that the reinsurer will pay. For example, the primary insurer may pay the first \$5,000 for covered services before reinsurance begins to pay, and then the reinsurer would cover 90 percent of expenditures for covered services up to \$500,000 (Figure 1). A primary insurer that wants greater protection (below the

Figure 1

Illustration of a Single Reinsurance Tier or Corridor



attachment point or above its limit on its present reinsurance contract) may buy one or more additional tiers of reinsurance—either from the same reinsurer or from another. For example, the primary insurer may retain risk from \$500,000 to \$750,000, but reinsure another tier of additional expenditures up to a \$1 million annual limit on coverage in the primary insurance contract. Because lower levels of expense for insured lives are more likely than very high levels of expense, reinsurance with a low attachment point is generally more expensive to buy than reinsurance with a high attachment point.

In practice, many insurers decline to buy reinsurance, even if it is available to them. The largest insurers (typically either large Blue Cross and Blue Shield companies or large national insurers) generally have a base of business that is so large that the marginal risk—even if very high cost—has little impact on average medical

costs company-wide. For smaller insurers that would naturally be more interested in reinsurance, the price of commercial reinsurance (if available) can be high, fueling their view that avoiding risk would be a better business proposition.

It is unclear how available reinsurance actually is to U.S. health insurers. Most of the reinsurance market is international, and largely focused on either life or property casualty insurance. Because the U.S. health insurance system is unique internationally, health reinsurance is in effect a niche sector of the reinsurance market. While some U.S. carriers reinsure major medical risk, the commercial reinsurance market in the U.S. appears to be quite small.

Components of Reinsurance

States that would consider establishing a reinsurance program to support individual or small-group coverage (or both) need to address a series of decisions about how the program would operate. A number of these decisions are reviewed in this section, with attention paid to the advantages and potential problems associated with alternative choices. No formal evaluation of the effects of these design choices has ever been conducted.

Ceding Risk at First Issue or Renewal

The states that have operated reinsurance plans offer examples of two models of reinsurance design: (1) those that permit primary insurers to obtain reinsurance when the policyholder renews coverage; and (2) those that permit primary insurers to reinsure only when the applicant is first enrolled.

Connecticut's small group reinsurance program offers an example of the first model. In Connecticut, any small-group insurer may reinsure individual covered workers or dependents, or entire small groups, in the reinsurance pool within 60 days of issuing coverage.⁶ Insurers may then reinsure their smallest groups (with just one or two employees) every third year at the anniversary date of first issue. New Hampshire's new small-group reinsurance program, which is much like that in Connecticut, also will allow carriers to reinsure at renewal every third year.

In contrast, the NAIC (National Association of Insurance Commissioners) small group reinsurance model act (which was developed after Connecticut's reinsurance program was in place) calls for reinsurance only at first issue. States that have adopted largely the NAIC model include Idaho, with respect to its small group market (Idaho also operates a very different reinsurance program for its individual market) and Wyoming (which opened a new small group reinsurance pool in 2007). Neither state allows insurers to reinsure at renewal. Wyoming's statute constrains the level of reinsurance premiums in order to encourage small group insurers to use the program at first issue. Nevertheless, it leaves Wyoming's insurers with an incentive to increase premiums steeply at renewal for claims experience, change in health status, or duration.⁷ Idaho also prohibits insurers from reinsuring small group lives at

⁶ Only permanent employees who work at least 30 hours per week (and their dependents) are eligible for reinsurance.

⁷ Wyoming constrains insurer rating of small group business at first issue on health status (+/- 30 percent per class) as well as industry (+15 percent), but does not constrain use of any other factors. Renewal rates are limited to medi-

renewal, but it structured its individual reinsurance program (as described in the next section) to reinsure new and renewed individual lives on the same basis.⁸

Reinsurance Benefit Design

Similar to a primary insurance plan, states that implement a reinsurance program must decide on the design of the reinsurance benefit. While intended to support the primary insurance benefit, the reinsurance benefit design may be very different. The reinsurance program may wrap around whatever products that an insurer may offer (as in Connecticut and the model NAIC act), it may itself have a specific benefit design (as in Idaho), or it may reinsure only standard products (as in Healthy New York). Each is described below.

In Connecticut (and in the NAIC model act), the attachment point for reinsurance coverage is set at \$5,000—that is, the primary insurer pays \$5,000 for covered services before the reinsurance is triggered. Idaho’s small group reinsurance program sets the attachment point much higher—at \$12,000. While a lower attachment point would tend to support less initial variation in rates quoted to small groups, it may also make reinsurance premiums higher and discourage insurers from using the reinsurance program.

Beyond the attachment point—or even to reach the attachment point—the reinsurance program may define covered services and cost sharing in terms of either the primary insurance contract or some alternative benefit design. For example, Connecticut’s small-group reinsurance program pays 90 percent of the program’s standard benefits or the benefits the insurer has sold, if they are not comprehensive benefits—a strategy designed to encourage insurers to offer benefits that are as comprehensive as the reinsurance program’s standard benefit. New Mexico and Arizona reinsure carriers that participate, respectively, in the Health Insurance Alliance and Health Care Group—both state-sponsored small-group purchasing pools. While there is relatively little variation in product designs within the pool, the products are not fully standardized and the reinsurance arrangement encompasses variations in each.⁹

In contrast, Idaho defines the reinsurance contract in terms of the standard small-group benefit designs established in its Small Employer Health Insurance Availability Act, and covers 90 percent of expenditures in any of three alternative tiers of coverage: \$13,000 beyond the attachment point (basic), \$88,000 (standard) or \$120,000 (catastrophic). Beyond these limits, the primary insurer is fully reinsured. However to understand the value of the reinsurance offered, the primary insurer must itself either offer the standard benefit design, or coordinate benefits between the primary insurance contract and the reinsurance design.

cal trend plus 15 percent for experience, health status, or duration.

⁸ Idaho’s statute provides that “If a reinsuring small employer carrier attempts to reinsure or reinsures an entire employer group, an employee, or a dependent of such employee that, immediately prior to the commencement of such coverage, it covered under a health benefit plan, the board shall assess all costs and losses incurred by the program for claims and administrative expenses relating to such group, employee or dependent of such employee only to the said reinsuring small employer carrier” (Idaho Statute 41-4711(17)).

⁹ Massachusetts and Alaska sponsor programs that reinsure all small group insurers in the market and reinsure with reference to the primary insurance design; both programs are extremely small. The Massachusetts program is closing as the Connector considers whether reinsurance will be needed to stabilize the combined market for small groups and individuals.

While a reinsurance benefit design that mirrors a standard primary coverage design may encourage wider use of the standard design, an alternative strategy is to reinsure only standard products. For example, Idaho's Individual High-Risk Reinsurance Pool (which operates separately from its Small Employer Health Reinsurance Program) reinsures only four standard products that all insurers in the individual market must offer guaranteed issue. Insurers may offer other products and deny applicants for those products. Premiums for the reinsured products are entirely standardized (they are the same regardless of the insurer or location), while insurers may set premiums for other (non-reinsured) products to reflect health status, claims, or duration (within rate bands), as well as any other rate factors they choose.

The Healthy New York program offers another example of state-sponsored reinsurance for only standard products. The Healthy New York program established the benefit design that it reinsures. The program is fully subsidized (participating insurers pay no reinsurance premiums) and both the Healthy New York product design and the reinsurance tier are scaled to meet the state's budget constraints for the program.¹⁰ For example, the Healthy New York product includes limited mental health; prescription drug coverage is offered as a rider. However, the program has lowered the reinsurance tier to reduce the premium for Healthy New York coverage (now set at 90 percent of covered expense between \$5,000 and \$75,000), as the enrolled population is healthier (and, therefore, the reinsurance costs lower) than was anticipated.

The selection of the reinsurance benefit design may have implications for the administrative cost of the reinsurance program, if not other implications as well. With respect to administrative cost, there is probably little difference between establishing a standard reinsurance benefit design and offering reinsurance that accepts the primary insurer's product design as its starting point. In either case, the reinsurance program must estimate the risk that it is assuming from the primary insurer; the process would differ only in that the use of a standard reinsurance benefit design would involve an additional coordination-of-benefits step.

In comparison, the strategy of reinsuring only selected, standard products is simplest and therefore probably most efficient administratively. Unlike the other reinsurance design strategies, it does not entail either estimation of risk against the unique product designs of the primary insurers or coordination of benefits. Instead, the reinsured product designs are relatively few and familiar; the task of evaluating risk relates only to the population that enrolls in the reinsured products.

These models may also differ in terms of the complexity of reserving. In general, programs that are less able to anticipate risk will require either larger reserves or authorization to assess insurers more frequently to cover losses. Nevertheless, in states that have (usually extremely small) reinsurance programs that reference each primary insurer's unique benefit design, estimation of reinsurance risk seems not to have been a problem: reinsurance premiums (when not capped) have covered very nearly all of reinsured claims. At the other extreme, a reinsurance program that is both larger and targeted to a subset of the population (for example, Healthy New York, which targets low-wage firms and workers) may have difficulty anticipating

¹⁰ The Healthy New York product is available only to low-wage firms and low-income workers. The state requires all HMOs to offer the Healthy New York product; currently at least one PPO also offers the product.

the extent of reinsured risk accurately in its start-up years, even when the reinsured product design is fully standardized.

Reinsurance Premiums and Premium Caps

In the private market, insurers may buy reinsurance by paying a premium. Public reinsurance programs also require insurers to pay a premium, and the reinsurance premium may be capped or uncapped. Both the Connecticut small group reinsurance program and the NAIC model cap premiums at 150 percent of the average standard small group rate in the state if the primary insurer cedes an entire group, and at 500 percent if the primary insurer cedes only specific workers or dependents.

If capped at relatively low levels, insurers have a greater incentive to cede risk, achieving the goals of reinsurance—to stabilize the market and improve access to and the affordability of primary insurance. However, with capped premiums, it is understood that the pool will not be fully premium financed; that is, assessments are expected and occur. The reinsurance premium structure in both Connecticut and the NAIC model is intended to encourage insurers to reinsure whole groups (not selected lives)—thereby reducing average losses in the reinsurance pool and, potentially, the need for assessments to finance losses. In Connecticut, the assessment to support the small group reinsurance pool in 2004 was approximately 1 percent of all insurers' small-group premiums that year (\$14 million on a base of \$1.3 billion).¹¹

In states where reinsurance premiums are not capped or the cap is high, it is unlikely that other insurers would be assessed any significant amount to finance losses. However, at higher levels of reinsurance premiums, fewer insurers use the pool—and the reinsurance program is less likely to affect the market.

Reinsurance Tiers

As described earlier (and depicted in Figure 1), private reinsurance is typically sold in tiers—for example, covering all or some portion of claims from \$5,000 to \$100,000, from 100,000 to \$200,000, etc. In contrast, public reinsurance programs have been structured relatively simply. Universally, they offer a single tier of reinsurance coverage, with just one attachment point and a coverage limit. For example, Healthy New York covers 90 percent of individual enrollees' covered expenses between \$5,000 and \$75,000 per year.

In principle there is no reason that a public reinsurance program could not offer multiple or alternative tiers of coverage. However, in practice a single tier is probably much simpler to administer and manage, and probably serves the market as well as a more complex system of reinsurance tiers would.

Specific and Aggregate Loss Reinsurance

In general, reinsurance programs have offered coverage on a specific basis: that is the primary insurer may reinsure either a specific group or specific individuals within a group. When a reinsured individual's claims reach the attachment point (or threshold), the reinsurance plan begins paying for all or part of further covered expenses, up to the limit of the reinsurance benefit. The primary insurer's decision to reinsure is based on the characteristics of the group or individual at first issue; it

11 K, Ideman, personal communication, January 9, 2007.

may also be based on claims experience if the program allows insurers to reinsure at renewal.

In contrast, reinsurance may also be offered on an aggregate basis. In this case, when the total costs of all insured lives in a block of business reach a threshold amount (say, \$500,000), reinsurance begins to pay. In effect, aggregate reinsurance ensures that the primary insurer is obligated to pay not more than a target level of loss calculated across its entire book of business. Aggregate reinsurance may be most feasible in the context of a purchasing cooperative or exchange. For example, New Mexico's Health Insurance Alliance operates an aggregate-loss reinsurance program for participating insurers. The Alliance withholds a reinsurance premium from the premiums that small groups, self-employed individuals, and HIPAA-qualified individuals pay to participating insurers, equal to 5 percent of premiums at first issue and as much as 10 percent of premiums at renewal.¹² In this program, participating insurers do not decide whether to reinsure: each year, the program pays the amount by which incurred claims and reinsurance premiums exceed 75 percent of earned premiums.

No state operates a market-wide aggregate loss reinsurance program that reinsures every product that insurers offer to individuals or small groups. Nevertheless, in some circumstances such a program could be feasible. For example, an aggregate-loss reinsurance program could efficiently support a very concentrated market (with just a few health insurers), such as has evolved in some states with relatively low population. In such a case, however, the state should also consider strong regulation requiring insurers to guarantee access to coverage as well as maintain high medical loss ratios that would be consistent with the lower level of risk that they retain.

Options for Public Financing

As described earlier, premiums are the principal source of financing for conventional public reinsurance programs. Like WSHIP, reinsurance programs historically have relied on authority to assess insurers that may not use the reinsurance program or may not even be eligible to use it, in order to cover losses net of premiums.¹³ Program losses may be anticipated (because premiums are capped) or unanticipated (for example, if reinsurance premiums simply did not anticipate actual experience).

The scope of reinsurance programs' authority to assess insurers varies among the states that operate them. The NAIC model act provides for an assessment on all carriers in the reinsured market—that is, a small-group reinsurance pool would assess all carriers' small-group premiums. An assessment that can be levied only on the market that it serves is intended to avoid effects on other markets—for example, to avoid increasing costs for large-group coverage and, therefore, biasing the market toward self-insurance. However, the NAIC model act also calls for attention to be paid to alternative financing if the assessment to cover net losses would exceed 5 percent of small-group premiums.

¹² For self-employed individuals who enroll in a Health Insurance Alliance plan, the reinsurance withhold is up to 10 percent in the first year and up to 15 percent for renewal years; it has averaged 10 percent, calculated across all small groups and self-employed individuals.

¹³ WSHIP assesses all insurers (including their Medicaid and Basic Health Plan enrollees) to cover program losses net of enrollee premiums.

While the NAIC model act does not specify how this should be done, the states' authorizing statutes may be clearer. For example, in Connecticut, if the assessment on small group premiums would exceed 5 percent, the excess is assessed on all health insurers on the basis of their total large group, small group, stop loss, and individual health premiums. Similarly, New Mexico assesses the premium income of all health insurers in the state to offset net losses in the reinsurance program for the Health Insurance Alliance, which serves small groups, self-employed workers, and individuals eligible under HIPAA. Idaho—which operates reinsurance pools for both the small group and individual markets—reinsures each separately, but merges the experience of both pools for purposes of assessment on all health insurers to cover any net loss.

However, some states—including Idaho—have authorized broader financing of their reinsurance programs. By spreading the cost of high-risk individuals and groups very widely, these programs minimize the premium impact on any one segment of the market. For example, in Idaho, a percentage of the premium tax on all carriers—across all lines of coverage—is allocated toward financing the combined losses of the individual and small group reinsurance pools. Similarly, Wyoming's small group reinsurance program provides for all licensed carriers to be assessed in proportion to their share of the premium tax paid. The New Hampshire small group reinsurance program is authorized to assess all licensed insurers on the basis of covered lives, including stop-loss carriers.

While no state has yet done so directly, some or all of the net loss of a reinsurance program could be financed from general revenues. However, a state that would permit insurers to offset the reinsurance assessment against their corporate income tax obligations would in effect already finance some of the cost of the reinsurance pool from general revenues.

Managing Medical Cost

Cost management is an essential concern in any system that promotes adequate coverage of services for high-risk individuals. Because reinsurance programs pool individuals who are either predictably high-cost (on the basis of a diagnosed condition) or whose medical cost experience has proven them to be high-cost, it would be natural to locate in the reinsurance plan efforts to manage medical cost effectively. In fact, conventional reinsurance programs historically have done little to manage the cost of reinsured groups or individuals, other than to require that the primary insurer retain some risk so as to be motivated to manage their medical cost.¹⁴

However, because the primary insurer's rate of return to care management drops in direct proportion to the risk that is assumed by the reinsurance pool, this strategy is unlikely to succeed. For example, if a dollar of expenditure to manage care would reduce cost by \$1.10 (a 10 percent rate of return), with 90 percent reinsurance, the rate of return drops to just 1 percent. At this low rate of return, the primary insurer would rationally look for an alternative—and more productive—investment of its resources. As a result, it probably makes very little

¹⁴ In general, reinsurance programs' inattention to cost management has been in response to carriers' assertions that they have state-of-the-art cost management strategies already in place. However, Texas's NAIC-model small group reinsurance program uses a specialized managed care firm to case-manage neonatal care. Carriers pay the first \$5,000 of the case management firm's cost in exchange for reimbursement of \$5,000 that they pay below the reinsurance attachment point (R. Bovbjerg and K. Ideman, personal communication, April 13, 2007).

difference whether a reinsurance program requires the primary insurer to retain some risk (for example, 10 percent as specified in the NAIC model act) or no risk (as in Connecticut). In either case, the insurer probably has no effective incentive to manage cost beyond the reinsurance threshold.

A number of cost management strategies may be available to reinsurance programs, depending on their scope and resources. For example, New York requires HMOs to offer the Healthy New York product, leveraging the cost advantage that HMOs already offer as effective care managers. Other insurers may offer the product, but potentially because of the difficulty of competing with HMOs' cost advantage, to date only one has done so.

A number of states—including Washington—have attempted to develop and apply disease- and case-management strategies in their high risk pools to moderate the cost of care. All of these efforts are relatively new, and none have been formally evaluated. Reinsurance programs also are a natural point to evaluate alternative care management strategies, identify best practices, and implement more uniform application of best practices as a benefit of reinsurance. Indeed, the inherent contradiction between an effective reinsurance program and incentives for the primary insurer to manage high-cost care once reinsured suggests that disease- and case-management efforts should strategically be located in the reinsurance program, not left to the primary insurer.

In addition, a large public reinsurance pool could amass valuable diagnostic and clinical practice data related to high-cost conditions—although no reinsurance program has yet done so. For example, the reinsurance pool could form the hub of a data cooperative among all insurers in the state, culling information on specific high-cost diagnoses to understand utilization patterns and apparent best practices. Such data could form the information base to help shape clinical protocols and inform public policy to constrain health care costs statewide. In Washington, the Puget Sound Health Alliance has pioneered such an effort across insurers, employers, providers, and patients; a reinsurance program—or, indeed, WSHIP—would be a natural and essential partner in a statewide enterprise of this type.

Alternative strategies: Risk Adjustment and High Risk Pools

Reinsurance is one of several strategies that states may consider to stabilize insurance markets and improve access to affordable coverage for healthy individuals and those with health problems alike. Both risk adjustment and high risk pools are alternative strategies that are intended to serve the same general goals. Risk adjustment and reinsurance are similar in that both can alter primary insurers' retained risk with some precision, and both are invisible to policyholders. However, they may have different impacts on insurers' retained risk and also practical implications for consumer access to coverage and cost management.

Risk Adjustment

Risk adjustment is a process of measuring and/or predicting the health expenditures of individuals (or groups) enrolled in competing insurance plans and adjusting payment to the plans commensurate with differences in their risk of health care expenditure. Similar to reinsurance, risk adjustment occurs “behind the scenes”: in practical terms, consumers are unaware of risk adjustments to the health plans that enroll them.

However, incentives for insurers in a risk adjustment program are different from incentives in a reinsurance program. While a reinsurance program pays the actual cost of covered expenditures above an expenditure threshold or within a corridor of expenditure, a risk adjustment program compensates insurers for the additional expected cost associated with enrolling groups or individual lives that are likely to be high-cost. Risk adjustment may be based on characteristics observed at the time of enrollment (ex ante), based on indicators of risk that emerge during the course of the year (ex post), or have elements of both.¹⁵

In Washington, the Health Care Authority (HCA) has operated a risk adjustment program since 1998 to support payment of capitated rates to health plans that contract to serve state employees.¹⁶ Similarly, Medicare risk adjusts capitation payments to both Medicare Advantage plans and stand-alone prescription drug plans (PDPs).^{17, 18}

New York is the only state that operates a risk adjustment program for all health insurers in the individual and small group health insurance markets.¹⁹ New York's risk adjustment system is designed "to promote an insurance marketplace where insurers and HMOs are reasonably protected against unexpected significant shifts in the number of persons insured" who are ill or have a history of poor health by pooling a portion of their costs.

From 1999 to 2005, the New York Insurance Department operated regional risk adjustment pools that paid risk adjustments to carriers based on a list of specified, high-cost medical conditions.²⁰ This risk adjustment process was intended to

15 Risk adjustment relies on the estimation of statistical models to predict total expenditures for individuals—commonly with a lag of one year, but sometimes within a year or concurrently. Typically, these models incorporate some demographic information and other non-clinical information, as well as clinical diagnoses. Each may group the more than 10,000 standard (ICD-9) clinical diagnostic codes differently to maximize the predictive power of the models and minimize sensitivity to coding anomalies. For example, some risk adjustment models group diagnoses that pertain to heart disorders separately from those that pertain to diabetes, but others may combine clinical groups that have similar costs or group conditions that affect the same body systems, or have similar persistence of illness or likelihood of recurrence. L. Greenwald. 2000. Medicare Risk-Adjusted Capitation Payments: From Research to Implementation. *Health Care Financing Review* (http://www.findarticles.com/p/articles/mi_m0795/is_3_21/ai_69434507, accessed April 14, 2007).

16 V. Wilson et al. 1998. Case Study: The Washington State Health Care Authority. *Inquiry* 35: 178-192.

17 G. Pope et al. Summer 2004. Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model. *Health Care Financing Review* (http://www.findarticles.com/p/articles/mi_m0795/is_4_25/ai_n6332425, accessed April 14, 2007).

18 MedPAC. September 2006. Part D Payment System (http://www.medpac.gov/publications/other_reports/Sept06_MedPAC_Payment_Basics_PartD.pdf, accessed April 14, 2007).

19 New York requires insurers that write small group or individual coverage to guarantee issue and use pure community rating. That is, insurers must accept all applicants for coverage and may vary premiums for any given product only by contract type (e.g., single and family) and location (by geographic region in the state).

20 New York's initial risk adjustment program (operated from 1993 to 1999) made risk adjustment payments to insurers based on the demographic composition of each insurer's enrollment relative to the regional average. Insurance Department of the State of New York. May 6, 2002. Fourth Amendment to Regulation No. 146. (11 NYCRR 361): Establishment and Operation of Market Stabilization Mechanisms for Individual and Small Group Health Insurance and Medicare Supplement Insurance (http://www.ins.state.ny.us/r_finala/2002/pdf/r146f4at.pdf, accessed April 20, 2007).

approximately equalize insurers' financial exposure over all insured lives in the region, but leave each insurer with a substantial incentive to manage the cost of high-cost enrollees' care effectively. New York's specified medical conditions pool was phased out in 2005 in response to carriers' concerns about inequities in the risk adjustment formula. In 2007, the Department established regional pools that pay annual risk adjustments based on actual expenditures, regardless of medical condition. Within the funding available to the risk adjustment program, carriers are eligible to receive risk adjustment funds for total claims paid in excess of \$20,000 for each insured by type of policy.²¹

High Risk Pools

High risk pools offer a source of coverage for high-risk individuals who are seeking to buy new coverage, change their individual health insurance plan, or move from group to individual coverage—but by definition, it is the only location that these individuals can find coverage. Paradoxically, a high risk pool is the most visible to consumers, and it is potentially the least effective in helping individuals find and retain adequate coverage.

Approximately 30 states (including Washington) currently operate high risk pools. None of these states requires guaranteed issue of individual coverage. Instead, the high risk pool supplements the individual market: individuals may access the high risk pool when they are denied coverage (by one or more carriers), are offered substandard coverage (with permanent exclusions of coverage, where such exclusions are permitted), or offered a substandard premium (that is, “rated up” because of a current or past health condition).

In principal, a high risk pool supports access to coverage with relatively little regulation of insurer practice regarding either the issue of coverage or how they set premiums to reflect (or avoid) risk. Insurers may deny or rate coverage, or design benefits to minimize (at least prospectively) any cross-subsidy from low-cost and high-cost enrollees. By keeping premiums for low-cost enrollees as low as possible, they attract favorable risk and minimize the chance of an adverse selection (or “death”) spiral.

An adverse selection spiral may occur when a health plan enrolls high-cost individuals and cross-subsidizes their costs by raising premiums for other enrollees. When low-cost enrollees leave to find coverage in a pool with more favorable risk (and therefore lower premiums) or they drop coverage altogether, the pool is left with a greater proportion of members who are high-cost. If the insurer increases premiums to cover the higher average cost of the remaining members, it may trigger additional low-cost enrollees to leave the plan. Ultimately, the risk pool collapses: the remaining members are largely or entirely high-cost and the premium becomes unaffordable.

²¹ The new regulation, promulgated by the Acting Superintendent on an emergency basis, assigns available risk adjustment funds (in 2007, \$80 million; in 2008, \$120 million; and in 2009 and subsequent years \$160 million) to seven insurance regions in proportion to total premiums in each region. Insurers are required to report total medical expense and cumulative total medical expense in categories ranging from \$10,000 or more to \$100,000 or more. Insurance Department of the State of New York. March 29, 2007. Fifth Amendment to Regulation No. 143 (11 NYCRR 361): Establishment and Operation of Market Stabilization Mechanisms for Individual and Small Group Health Insurance and Medicare Supplement Insurance (http://www.ins.state.ny.us/r_emergy/pdf/re146a5t.pdf, accessed April 20, 2007).

In practice, many states (including Washington) have sought a balance between the amount of risk that the high risk pool accepts and the amount of risk that the market retains. This can be achieved in a variety of ways—for example, by setting high risk pool premiums well above market rates (so that individuals are inclined to accept a substandard premium, if they can afford to do so), by sending “insurable” high risk pool applicants back into the market guaranteed issue (as in Utah);²² by limiting insurers’ rate of denial and substandard offer, and the conditions that trigger denial (as in Washington); or by limiting the duration of high risk pool participation and sending “graduates” back to the market guaranteed issue (as in California).

These strategies probably force insurers to retain more risk than they otherwise would. By reducing use of the high risk pool, the total amount that insurers are assessed to maintain relatively affordable high risk pool premiums may be lower. Thus, states pursue these strategies largely on the basis of political judgments about the level of assessments that insurers will tolerate—not necessarily to minimize either premium levels or volatility, or to maximize individuals’ access to coverage.

As with both reinsurance and risk adjustment, the ultimate impact of a high risk pool on access to affordable coverage has not been evaluated formally in any state. However, the very low participation in most high risk pools offers *prima facie* evidence that the pools probably have very little impact on the level of premiums in the market. Instead, high risk pools are intended to “let the market work.” Unlike either reinsurance or risk adjustment, a high risk pool simply accommodates insurers’ inclination to avoid risk while ensuring that every individual ultimately can obtain coverage to some degree, if they can afford it. In Washington, insurer denials are probably more standardized than in other states (WSHIP uses a standard list of health conditions to identify uninsurable risk).

States that elect to operate a high risk pool must operate a program with benefits that are more comprehensive than can be found in the market—for example, covering drugs for HIV and cancer. While the state’s administrative cost for operating a high risk pool is characteristically less than a commercial insurer, the isolation of high-cost individuals in a single pool with a comprehensive benefit makes high risk pools costly both for individuals who buy high risk pool coverage and for the state. In addition, because high risk pools allow insurers to avoid risk only at the time the enrollee applies for coverage, they are likely to have no effect on premium increases at renewal. Even when premium increases are constrained as a mark-up on medical cost growth, premium increases in states that rely on a high risk pool can be very steep.

While all state high risk pools subsidize premiums, they still are unaffordable for many who would need high risk pool coverage—and especially for older adults who are most likely to be denied coverage in the market. In Washington, the WSHIP board targets rates at 110 percent of the standard rate—much lower than in most other states that operate high risk pools. However, because market rates vary by age—and because WSHIP offers comprehensive benefits that individuals with health problems need but cannot generally obtain in the market—WSHIP premiums are very steep for older adults, especially, even with a deductible as high as \$1,500. In addition,

22 Utah allows health rating, so that individuals sent back to the market may be rated on health status.

the process of application and denial that makes an individual eligible to apply for high risk pool coverage is itself expensive and time-consuming.²³

Finally, high risk pools commonly exclude coverage for as much as one year for the preexisting conditions that in all likelihood were the very reason the individual was denied market coverage. The purpose of this provision is to deter individuals from seeking insurance only when they have an immediate need for care—for carriers that finance high risk pool losses, tantamount to reducing the premium revenues they would obtain from individuals while healthy.

Washington has attempted to minimize the waiting period in WSHIP for coverage of a preexisting condition—requiring a waiting period of 6 months and crediting any prior coverage against the waiting period.²⁴ Nevertheless, for individuals without creditable prior coverage, the presence of preexisting condition exclusions makes the cost of enrolling in WSHIP very high: they face the prospect of high premiums for coverage that for six months will not pay for the care they need.

Considering all of these factors together, it is unsurprising that, in nearly all states and also in Washington, there appears to be a significant gap between denial of market coverage and entry into the high risk pool. Nationally, for all individual products in states that do not require guaranteed issue, an estimated 49 percent of applicants were either denied (12 percent) or made a substandard offer of individual coverage (37 percent) in 2001.²⁵ Characteristically, high risk pool coverage has accounted for less than 2 percent of the individual market, although in some states, enrollment has increased in recent years as they have used their high risk pools to comply with HIPAA portability requirements.^{26, 27} WSHIP estimates that it enrolls just 17 percent of rejected applicants, and that 30 percent of those rejected remain uninsured a year later.

23 Insurers commonly require payment of at least one month's standard premium at the time of application, it may be returned if the application is denied but is not returned if the application is accepted, even if the applicant ultimately does not enroll in coverage. The underwriting process after application normally takes 30 to 60 days—at least half of the 63-day period allowed under Health Insurance Portability and Accountability Act (HIPAA) for guaranteed issue after leaving group coverage.

24 Coverage is excluded for preexisting conditions (except pregnancy) for six months, if treatment was recommended or received within 6 months before the effective date of WSHIP coverage. This exclusion is waived if a similar exclusion was satisfied under any prior health insurance held within 63 days of application to WSHIP.

25 AHIP Center for Policy and Research. 2005. Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits (http://www.ahipresearch.org/pdfs/Individual_Insurance_Survey_Report8-26-2005.pdf)

26 L. Achman and D. Chollet. 2003. Insuring the Uninsurable: An Overview of State High risk pools (http://www.cmwf.org/publications/publications_show.htm?doc_id=221291).

27 HIPAA required that some provision be made in all states to ensure that individuals with significant coverage in the group market are able to obtain guaranteed-issue coverage in the individual market, if they apply for coverage within approximately two months of leaving group coverage and have exhausted all available group continuation options (for example, under COBRA) and are ineligible for coverage from any public program.

Considerations for Washington State

Washington State's WSHIP program serves individuals who are denied coverage for an individual health plan. With respect to individuals whom insurers accept for coverage, individual renewal is guaranteed (in compliance with HIPAA); once coverage is issued, the insurer has no subsequent opportunity to direct a high-cost enrollee to WSHIP. Therefore, despite WSHIP, insurers continue to have a strong incentive to avoid risk by rating, benefit design, or both. In some states, insurers have responded to such incentives also by reviewing applications for misrepresentation and canceling policies issued to individuals who become high-cost.

While WSHIP may serve the individual market imperfectly, insurers do not have even that mechanism to help manage risk in the small group market. Guaranteed issue and tight rating bands in the small group market are problematic for small insurers, especially. Some believe that such regulation may contribute to consolidation in insurance markets—although preliminary research suggests that regulation has not been a significant factor in the growing concentration of markets.²⁸

As in many states, the health insurance market in Washington is very concentrated. Just two insurers account for approximately 85 percent of the small group market, and three insurers account for approximately 90 percent of the individual market. In light of the concentration that already exists, it is unlikely that the largest insurers in Washington would benefit significantly from a conventional reinsurance program. Very large insurers can spread a low incidence of high-cost enrollees over a sufficient base of covered lives so that premiums are not significantly increased overall.

However, Washington's smaller carriers might benefit substantially from reinsurance both in the group market and in the individual market—where it is difficult for WSHIP to substantially reduce incentives to avoid risk. Either reinsurance or risk adjustment—or both—in these markets could make smaller insurers more cost-competitive, reduce their incentives to avoid risk, and improve high-risk individuals' access to coverage.

Moreover, despite larger carriers' usual opposition to public programs for which they could be assessed to support losses, it may be possible to structure a reinsurance and/or risk adjustment program that would significantly benefit large insurers as well. Such a program would have at least two primary goals: (1) expanding primary coverage that offers adequate benefits to high- and low-risk individuals alike; and (2) supporting stable premiums and coverage in an accessible market, where insurers have little or no incentive to either avoid risk or consolidate to manage risk.

Program features that might accommodate each of these goals are discussed below. The section concludes with a discussion that each also might play in a combined

28 D. Chollet and G. Mays. 2002. Leaving the Game: Insurer Withdrawals from Group and Individual Health Insurance Markets. Presentation to the AcademyHealth Annual Research Meeting (unpublished).

small group and individual market and/or in supporting an individual mandate. Both provisions are features of the reforms that Massachusetts enacted last year, and both also are envisioned in the Governor's reform proposal in California.

Expanding Primary Coverage

High risk pools, reinsurance programs, and risk adjustment programs are all intended to make coverage more available to high-risk individuals. However, whether they are able to significantly expand primary coverage among high- and low-risk individuals alike relates directly to how they are financed and structured.

Public Subsidies

While conventional reinsurance pools commonly use assessments on health insurers to fund net losses, some use subsidies from other sources to subsidize reinsurance premiums. The effect of such subsidies can be lower cost for primary coverage. For example, with Healthy New York's reinsurance, participating HMOs have reduced premiums for eligible small groups and individuals by 25 to 30 percent or more.^{29, 30} In New York, the state's tobacco settlement trust fund supports the subsidy. Assuming adequate regulatory oversight, such a deep subsidy in a risk adjustment program could have a similar effect. In New York—which also risk adjusts coverage—the risk adjustment program is intended only to stabilize the individual and small group markets; it is entirely funded by assessments on insurers in these markets.

In any discussion of public subsidies, efficient targeting is a concern. Because only low-wage small groups and low-income workers are eligible to enroll in Healthy New York coverage, targeting the reinsurance subsidy relatively narrowly is not a problem: the subsidy necessarily benefits low-wage and/or low-income workers (and their employers) who would have difficulty affording coverage. However, targeting subsidies to specific income groups in a reinsurance program that is market-wide presents a greater challenge, and subsidized reinsurance may not be the most efficient means for doing so.

Nevertheless, in Washington and nationally, there is a strong correlation between low income and poor health status. In 2006, 18 percent of Washington's population below poverty and 14 percent near poverty reported themselves to be in just fair or poor health—compared with 5 percent of the population above 400 percent of poverty (Table 1). Thus, targeting resources to individuals with significant health problems (in addition to resources already directed to the Washington Basic Health Plan) would substantially benefit lower-income residents if they had an equal opportunity to obtain coverage.

29 J. Tallon. 2005. Options for Increasing Affordability of Coverage through Public Subsidies. Presentation to United Hospital Fund Roundtable on Health Insurance for New Yorkers, New York City (unpublished).

30 Healthy New York paid 29 percent of enrollees' medical costs in calendar year 2004, averaged across small-group enrollees (26 percent), self-employed enrollees (29 percent), and other individually insured workers (29 percent). EP&P Consulting, Inc. 2006. Report on the Healthy NY Program 2005, Prepared for State of New York Insurance Department (<http://www.ins.state.ny.us/website2/hny/reports/hny2005.pdf>, accessed March 12, 2007).

Table I
**percent of the population in Washington reporting
 excellent to poor health status, 2006**

| | Total | Excellent or Very Good Health Status | Good Health Status | Fair or Poor Health Status |
|-----------------------------|--------|--|-----------------------|-------------------------------|
| Total | 100.0% | 65.4% | 56.1% | 9.3% |
| Poor: under 100% FPL | 100.0% | 45.4% | 27.4% | 18.0% |
| Near Poor: 100-200% FPL | 100.0% | 56.4% | 42.2% | 14.2% |
| Middle Income: 200-400% FPL | 100.0% | 66.8% | 59.0% | 7.8% |
| Upper Income: Over 400% FPL | 100.0% | 75.2% | 70.0% | 5.2% |

Source: Washington State Planning Grant on Access to Health Insurance, Office of Financial Management.

Program Structure

Like a very small high risk pool, a very small reinsurance or risk adjustment program is unlikely to make primary insurance substantially more available or affordable to individuals or to small groups. Conversely, a program that is structured so that use of the program is automatic is most likely to impact the primary insurance market.

Healthy New York is a good example of a program that is structured so that use of the program is automatic. Healthy New York is successful in reducing premiums not only because reinsurance is free to participating insurers, but also because the program universally reinsures all enrollees. As a result, participating insurers do not need to anticipate which enrollees will become high cost. In addition, they retain no risk that, in light of an individual's subsequent claims experience, they would have reinsured. The fact that Healthy New York insurers pay no reinsurance premium makes automatic reinsurance a good business proposition, when they might otherwise be reluctant to send risk and revenues to the reinsurance program.

A risk adjustment program could achieve the same result. Insurer participation could be universal, and the benefit would be automatic: that is, all insurers, large and small, would benefit and pay to the extent that they did or did not enroll high-risk individuals. In addition, although risk adjustments are conventionally revenue neutral, they could be publicly subsidized. Subsidized risk adjustments would reduce the amount that insurers with a relatively favorable selection of risk would pay to support risk adjustment payments to insurers with less favorable risk.

Stabilizing Accessible Markets

States that have required individual and small group insurers to accept all applicants for coverage and also to community rate have long been concerned about helping insurers to manage risk within those constraints. Constraints on rating can make it difficult for any carrier to write coverage, but especially smaller carriers. However, research indicates that individuals with health problems are more likely to

obtain coverage in markets where coverage is community rated.^{31, 32} This paradox suggests a useful role for either a public reinsurance program or a system of risk adjustments to support the entry of high-risk individuals and families and access to adequate benefits in a market that does not discriminate on health status.

Also, it may be easier for insurers to maintain a relatively high statutory minimum loss ratio with such supports. Washington requires each individual health insurer to pay the difference between 72 percent and its actual loss ratio (if lower) into WSHIP.³³ However, in a market where carriers could anticipate a more stable loss experience, a much higher minimum loss ratio could be feasible—reducing overall premiums and/or returning higher value to policyholders. In California, the Governor has proposed requiring small group and individual insurers to achieve a minimum loss ratio of 85 percent. In Washington, setting reinsurance premiums low (that is, capping and subsidizing them) or subsidizing risk adjustments—and making both automatic—might support a minimum loss ratio that is substantially higher than some carriers now achieve.

Combining the Small Group and Individual Markets

Effective in 2007, Massachusetts has combined its small group and individual markets in order to coordinate regulatory support of coverage in both. To help carriers manage risk in the combined market, Massachusetts loosened its very tight restrictions on rating for group size. Nevertheless, it is estimated that some carriers' small group premiums in the merged market will increase as much as 4 percent.³⁴ The state is considering reinsurance—either for the Connector (which will manage subsidies in the combined market) or market-wide—as one way to soften the impact on group premiums and stabilize premiums in the merged market going forward.

In Washington, merging the small group and individual market could achieve a number of objectives. As in Massachusetts, the most important of these may be the potential to reduce premiums in the individual market. However, in Washington, the ability of insurers to select low-risk small groups into association plans might complicate this prospect. To the extent that insurers succeed in both avoiding high risk in the individual market and selecting low-risk small groups into association plans, combining the small group and individual markets could actually increase individual premiums, if association plans were to continue in parallel with the combined market.

Some states (not Washington) allow or require small-group insurers to consider self-employed individuals as groups of one, giving them greater protections (such

31 K.I. Simon. 2005. What Have We Learned About Regulation in the Small Group Market? *State Health Insurance Market Reform: Toward Inclusive and Sustainable Health Insurance Markets*. J. Cantor and A. Monheit, eds. New York: Routledge Press.

32 D. Chollet. 2005. What Have We Learned About Regulation in the Individual Market? *State Health Insurance Market Reform: Toward Inclusive and Sustainable Health Insurance Markets*. J. Cantor and A. Monheit, eds. New York: Routledge Press.

33 Maine, Maryland, and New Jersey also have minimum loss ratios in statute. Of these, New Jersey is the only state that requires small group insurers to rebate to policyholders the difference between 75 percent and their actual loss ratio each year.

34 Conversely, individual premiums were estimated to drop by 2 to 50 percent in the merged market. Gorman Actuarial LLC. 2006. Impact of Merging the Massachusetts Small Group and Individual Markets. Report Prepared for the Massachusetts Division of Insurance and Market Merger Special Commission [http://www.mass.gov/Eoca/docs/doi/Legal_Hearings/NonGrp_SmallGrp/FinalReport_12_26.pdf].

as guaranteed issue and community rating) than they would have in the individual market. However, by reducing the size of the individual market, the general impact of these laws probably has been to further reduce the capacity of insurers to tolerate high-cost enrollment, encouraging them to avoid risk within the limits that regulation allows and discouraging them from writing individual coverage at all. While a high risk pool may support an individual market (albeit imperfectly), federal rules requiring guaranteed issue for groups of 2 to 50 make a high risk pool impractical for supporting a combined market.

Either reinsurance or risk adjustment can support the application of the same rules for coverage of both small groups and individuals—guaranteed issue, community rating, and rate bands to improve affordability. However, neither is likely to succeed in stabilizing a combined market unless coupled with provisions that control adverse selection market-wide. In a market where individuals enter when in need of health care and exit once their needs are met, extreme adverse selection among individuals can destabilize the entire combined market, despite reinsurance. While the lower cost of individual insurance in a combined market would itself help to address the problem of biased entry and exit, it might still be insufficient. But the availability of deeply subsidized primary coverage—together with an individual mandate—could help to stabilize individual enrollment, with either reinsurance or risk adjustment financing the relatively rare individual or group with extraordinarily high health care costs.

Supporting an Individual Mandate

Easy access to individual coverage is fundamental to the success of an individual mandate. States like Washington may consider a number of measures to improve access to individual coverage (and have done so) even without an individual mandate, but enacting an individual mandate requires states to consider “no fail” strategies that they might not otherwise consider as seriously. In Massachusetts—the only state with an individual mandate in law—the initial effort at a “no fail” strategy is the new Connector, an entity that will perform a number of functions to facilitate coverage (including administration of subsidies) and will be sufficiently large and visible for every resident to find it with ease.^{35, 36}

One could imagine an individual mandate without such an entity—if the state attended to the basic question of affordability, performed some functions that made it easier for residents to become and remain insured (such as helping employers to establish Section 125 plans and pooling contributions from multiple employers), and removed practical barriers to obtaining individual coverage. For example, in Idaho

³⁵ The Commonwealth Health Insurance Connector will connect individuals and small businesses with health insurance products. Individuals who are employed will be able to purchase insurance through the Connector using pre-tax dollars. The Connector will allow for portability of insurance as individuals move from job to job, and permit more than one employer to contribute to an employee’s health insurance premium. The Connector will be operated as an authority under the Department of Administration and Finance and overseen by a separate, appointed Board of private and public representatives [<http://www.mass.gov/legis/summary.pdf>].

³⁶ Even so, affordability remains a significant challenge for the state. At this writing, Massachusetts anticipates exempting as many as 20 percent of uninsured adults from the state’s individual mandate, effective July 1, 2007, based on calculations that even the lowest-cost insurance would not be affordable for an estimated 60,000 people with low and moderate incomes who do not currently qualify for state subsidies. A. Dembner. April 12, 2007. Health Plan May Exempt 20% of the Uninsured. The Boston Globe (http://www.boston.com/news/local/massachusetts/articles/2007/04/12/health_plan_may_exempt_20_of_the_uninsured/, accessed April 13, 2007).

every insurer in the individual market is required to offer five standard reinsured “high risk pool” products at a statewide pure community rate.³⁷ Although Idaho does not mandate individual coverage at present, such easy access to guaranteed-issue individual coverage could be part of the platform necessary for doing so, if other aspects of the reinsured plans that deter enrollment were addressed.³⁸

Options for replacing WSHIP

Drawing from the discussion above, selected criteria for considering the relative merits of reinsurance, risk adjustment, and high risk pools are summarized in Figure 2. The assigned rankings assume that reinsurance would absorb substantial high risk and, similarly that risk adjustment would normalize the risk that primary insurers retain. In either case, this would entail building the programs’ financing and structure to achieve these results.

The following discussion summarizes the pros and cons of each option—reinsurance, risk adjustment, and continuing a high risk pool—on criteria where each would be expected to perform particularly well or not.

- **Reinsurance.** The principal advantage of reinsurance, even if available only at first issue, is that it supports “one-stop shopping” for consumers and also freedom of movement among individual insurance plans—advantages that they do not now have in Washington. As a result, the gap that WSHIP has observed between denial of coverage and WSHIP enrollment could be substantially reduced or eliminated.

Even when insurers are able to avoid accepting individuals with health problems, in any insurance pool health problems are likely to emerge over time. Therefore, if reinsurance also were available to carriers at renewal, it could perform much better on a number of the criteria identified in Figure 2, simply because it would finance enrollees as they became high-cost. With such a program in place, insurers would have very little incentive to avoid risk at first issue; also, renewal rates could be lower, improving retention. Such a program could serve the individual and small group markets equally well, separately or in combination, and it could support access to comprehensive coverage under an individual mandate.

Finally, because a broad reinsurance program would touch most if not all people who incur high cost during any year of individual coverage, it would have both reason and opportunity to advance strategies to improve the outcomes and efficiency of care for high-cost diagnoses. However, because it may largely remove incentives for insurers to constrain cost, it would be important to

³⁷ The pool plans include a Basic and a Standard Plan, two catastrophic plan designs, and an HSA-qualified (high deductible) plan. In 2006, most enrollees participated in either the standard or 20-percent coinsurance catastrophic plan options.

³⁸ Some aspects of Idaho’s program probably deter greater enrollment in reinsured plans (as in the individual market more generally). These include a 12-month preexisting condition exclusion, high coinsurance rates (ranging from 20 percent in the Catastrophic B plan to 50 and 60 percent in the basic and HSA-compatible plans, respectively), and steep premiums (for older men—and also for older smokers, either men or women—exceeding \$1,000 per month), despite caps on reinsured product premiums set at 125 to 150 percent of standard market rates.

establish standard reporting by insurers of specific high-cost diagnoses (such as the standard list that WSHIP maintains) and to work with insurers to implement best-practice disease management, even before significant costs are incurred.

Figure 2

**Likely Effectiveness of Reinsurance,
Risk Adjustment, and High Risk Pools on Selected CHARACTERISTICS**

| Characteristic | Reinsurance | | Risk Adjustment | | High Risk Pool (5) |
|---|--|---|--|--|-------------------------------|
| | (1) Available only when coverage is first issued | (2) Also available when coverage is renewed | (3) For characteristics observed when coverage is issued | (4) For major health conditions that emerge during the coverage period | |
| Reduction of insurer incentives to avoid risk | Medium | High | Medium | High | Low |
| Ability of insured individuals to find coverage easily and move among plans | High | High | High | High | Medium/ Low |
| Incentives for the primary insurer to manage high costs effectively | Medium/ Low | Low | High | High | Medium/ Low |
| Opportunity to rationalize high-cost care management statewide | Low | High | Low | Low | Low |
| Stabilize a merged small group and individual market with no individual mandate | Medium/ Low | Medium | Medium | Medium | Medium/ Low |
| Stabilize a merged small group and individual market with an individual mandate | Medium | High | Medium | High | Low |
| Support access to adequate coverage with an individual mandate | Medium | High | Medium | High | Low |

- **Risk adjustment.** Like reinsurance, risk adjustment is likely to perform much better on the criteria identified in Figure 2, if it is structured to adjust on an ongoing basis for differences in enrolled risk. But even risk adjustment only at first issue would offer some of the same benefits as reinsurance—that is, consumers could be guaranteed issue of individual coverage by any insurer they approach. However, such a system would perform at most moderately well on all other criteria. Because it would leave insurers with full risk at renewal, it would do little to reduce their incentives to avoid risk at first issue—but simply because risk adjustment only at first issue would leave carriers with substantial risk, it would maximize their incentives to manage care effectively for the high-cost individuals whom they do enroll.

If risk adjustment were available on an ongoing basis—at least annually on all insured individual lives—insurers would have relatively little incentive to avoid risk, and they still would have strong incentives to manage care effectively. In such a system, insurers could only benefit from effective management of high-cost illness, regardless of the level of risk adjustment they paid or received. However, because the program would not directly touch insured lives, the program would have no direct line of access to high-cost patients and, therefore, potentially less authority to coordinate effective protocols for disease and case management statewide. Such a system of risk adjustments could perform equally as well as reinsurance at issue and renewal to support a combined individual and small group market, and also to support access to coverage under an individual mandate.

- **High risk pool.** On any of the criteria identified in Figure 2, a high risk pool is unlikely to perform as well as either a reinsurance program or a risk adjustment program—presuming that they are structured to succeed. A high risk pool is probably the least effective in rewarding insurers for developing effective cost management strategies, simply because it accommodates insurers' inclination to avoid risk, but leaves them with full risk at renewal. With a high risk pool, insurers probably also are more inclined to offer narrow benefits (for example, without coverage of drugs to manage cancer) than they would in a system of reinsurance or risk adjustment, if available at renewal.

Because a high risk pool is more costly for enrollees than if they were accepted at standard rates in the individual market, it is likely to perform less well than either reinsurance or risk adjustment to make coverage accessible to individuals. In addition, because the high risk pool becomes the only source of individual coverage for people who are once denied in the market, it is unlikely to offer either the access to coverage or choice of plans that individuals might expect, if they were required under law to become and remain insured.

Finally, federal rules that require guaranteed issue to small groups and guaranteed continuity at renewal for both small groups and individuals make it possible for insurers to use a high risk pool only for individual coverage and only at first issue. Thus, to the extent that Washington would consider merging its small group and individual markets, a high risk pool cannot serve both.

In summary, while either risk adjustment or reinsurance generally fare better on the selected criteria, to do so both must be structured to remove risk at both issue and renewal of coverage, and even then they are likely to succeed on somewhat different criteria. Both could perform very well in reducing insurer incentives to avoid risk and facilitating individual access to adequate coverage.

However, a comprehensive reinsurance program would minimize insurers' incentives to manage high cost—in effect, requiring that the reinsurance program take a strong role in managing medical cost. By taking on that role, a comprehensive reinsurance program would offer an excellent opportunity for bolstering efforts to develop and coordinate best practices in high-cost disease and case management statewide. Conversely, a comprehensive risk adjustment system would maximize insurers' incentives to manage cost. By diluting the need for statewide coordination of best practices, it would not necessarily promote progress toward understanding and adopting effective cost management statewide.

Either risk adjustment or reinsurance that allows insurers to cede risk at renewal may be more likely to reduce the volatility of premiums over time and, therefore, ultimately support more stable coverage and less churning.³⁹ However, it is incumbent on the state to ensure that the benefits that insurers offer are adequate for individuals with extensive health care needs.

In contrast to either reinsurance or risk adjustment, a high risk pool is at a disadvantage with respect to all of the criteria identified in Figure 2. In addition, pressure from insurers to keep a high risk pool small in order to avoid assessments to cover net losses appears to be a difficult if not insurmountable obstacle. Because the high risk pool cannot serve the small group market and its size for individual coverage is practically constrained, the ability of a high risk pool to support broad objectives—such as reducing the number of uninsured and systematically managing high health care costs—is extremely limited.

Finally, the options identified in Figure 2 should not be regarded necessarily as mutually exclusive. It would be possible to combine some features of risk adjustment and reinsurance, if such a strategy served the needs of insurers and consumers in meeting the state's overall objectives. For example, one might imagine a system of risk adjustments combined with reinsurance that has a relatively high attachment point. Such a system could leave insurers covering chronic conditions—and with the financial incentive to manage chronic care effectively. But reinsurance would cover extremely high-cost conditions (for example, severe traumatic injury, very low birth-weight infants, and congenital birth defects). With such an arrangement, insurers would have low incentives to avoid risk, but they would retain a significant incentive to manage cost. Overlaying such a structure to promote access and stability, the state could then determine the extent to which it would fiscally be able to subsidize reinsurance, risk adjustments, or both, to encourage individuals to find and maintain health insurance.

³⁹ Churning—that is, people dropping coverage to enroll in another plan—is a significant source of nonmedical cost in private health insurance plans. The term connotes changes in plan enrollment that are driven by insurer strategies intended to avoid retention of high-risk enrollees.

Recommendations for Further Study

Policymakers in Washington probably would benefit from having additional quantitative information about the potential costs and benefits of either reinsurance or risk adjustment as alternatives to WSHIP for management of the individual market, as well as the potential for either to stabilize and expand small group coverage. Specifically, it would be important to understand:

- How much the risk that nongroup insurers now hold varies among insurers, both for newly issued coverage and for renewal coverage by date of issue. This information would help policymakers to understand the likely value of structuring either reinsurance or risk adjustment to accept risk on an ongoing basis. It also would offer guidance about how deep reinsurance must be (or how large risk adjustment must be) to offset differences in risk variation—recognizing that observed variation (especially at first issue) is reduced by both rating and benefit design to avoid risk. While programs that accept risk on an ongoing basis probably would be substantially larger than those that accept risk only at first issue, they would also be commensurately more successful in ensuring access and stabilizing premiums and coverage.
- How much the risk that insurers now hold varies between the individual and small group markets for both newly issued coverage and for renewal coverage. This information would help policymakers to understand whether the same kinds of programs may be necessary and useful in both markets, and which might better serve a merged market.
- The relative total cost of a reinsurance system, a system of risk adjustment, and a high risk pool. Such information should include an understanding of their relative potential for managing high-cost health care efficiently, and also the nonmedical costs of each system. Consideration of nonmedical costs should include attention to total administrative cost as well as the potential for supporting a much higher minimum medical loss ratio for insurers in the market.
- The potential relative effects on expansion of health insurance coverage of a public subsidy offered through the alternative systems—reinsurance, risk adjustment, or WSHIP premiums. This inquiry should consider both the potential for targeting subsidies to low-income individuals within each program, and whether explicit targeting to low-income individuals is likely to achieve substantially higher levels of coverage than a broader program focused on subsidizing and managing high-cost conditions and care.

An addendum describes Washington's development of analytic capacity with the Reinsurance Institute.

REINSURANCE INSTITUTE:

Washington State's Participation

REINSURANCE INSTITUTE: Washington State's Participation

March 2007

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| WHAT IS THE REINSURANCE INSTITUTE? | <p>The Reinsurance Institute is technical assistance funded by The Robert Wood Johnson Foundation's State Coverage Initiatives (SCI) program (see http://www.statecoverage.net/reinsuranceinstitute.htm). It offers short-term access to consulting services provided by reinsurance experts from the Urban Institute who are supported by actuaries from Actuarial Research Corporation. Washington is one of only three states awarded the opportunity to participate in state-specific modeling work provided by the Reinsurance Institute¹.</p> |
| WHAT WILL WE GET FROM IT? | <p>The intent of the Reinsurance Institute is to provide technical assistance in 3 ways: (a) building a model that estimates the likely impact of implementing public reinsurance in Washington (b) interacting with state policy makers to apply the model to Washington state and (c) offering lessons learned from other states' reinsurance activities, including guidance on administrative, operational and funding issues.</p> |
| WHAT REINSURANCE APPROACH CAN WE MODEL? | <p>The Reinsurance Institute model has been built to simulate variations on the Healthy New York approach to reinsurance. In brief:</p> <p>Healthy New York provides affordable, limited, standardized, private health insurance benefits for employees in low-wage small firms and for low-income individuals. The program reinsures 90% of claims expenses for high cost individuals whose cumulative annual claims total between \$5,000 and \$75,000. Reinsurance is funded by public moneys from New York's tobacco settlement.</p> <p>The model for Washington uses the best available data on state health care costs; insurance; and population and business characteristics to generate estimates that reflect Washington's market circumstances. It will allow considerable flexibility in defining the target population; insurance market; benefits offered; and percent and corridors of claims expenses to be reinsured. For example, we could estimate the impact of reinsuring the entire small group market, the combined small group and nongroup markets (with and without high risk pool enrollees) or just currently uninsured low-wage employees in small firms. The precision of estimates will vary based on the underlying data and the degree to which actuarial assumptions are needed on the value of benefits.</p> |
| WHAT CAN WE LEARN FROM THE MODEL? | <p>While no model can predict with certainty the <i>precise</i> impact of public reinsurance on health plan, employer, and individual behavior, and results from models using different data sources and assumptions may differ, the Reinsurance Institute model will give us a good sense of the range of <i>likely</i> effects in Washington. It will help us understand:</p> <ul style="list-style-type: none">▪ Differences in costs to individuals, employers, the state, and health plans from varying reinsurance parameters. |

¹ In August 2006 the Office of Financial Management and the Office of the Insurance Commissioner jointly applied for Washington to participate in the Reinsurance Institute. In November 2006, Rhode Island, Washington and Wisconsin were selected to receive technical assistance through the Reinsurance Institute.

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| WHAT CAN WE LEARN FROM THE MODEL? <i>(continued)</i> | <ul style="list-style-type: none"> How health expenditures are distributed over the population, by age, health status, and various risk pools. Reductions in health insurance premiums for groups or individuals targeted. Potential changes in employers' decisions to offer coverage. Potential changes in individuals' decisions to purchase coverage. |
| WHEN WILL IT HAPPEN? | <p>The Urban Institute has already made considerable progress in building a reinsurance model that fits the demographics and health coverage offered in Washington. Steps taken and to be taken include:</p> |
| Nov 06 | Washington awarded Reinsurance Institute opportunity |
| Dec 06 – Feb 07 | Generic reinsurance model designed |
| Feb 07 – Apr 07 | Model refined/tested to fit Washington-specific details |
| Mar 07 – Apr 07 | Reinsurance options identified for modeling |
| Apr 07 – May 07 | Impacts modeled by Reinsurance Institute consultants |
| Jun 07 – Jul 07 | Final results turned over to Washington |
| WHERE DO I GO FOR MORE INFORMATION? | <p>Jenny Hamilton 360-902-0634, Jenny.Hamilton@ofm.wa.gov Michael Arnis 360-705-7043, MichaelA@oic.wa.gov Vicki Wilson 360-902-0652, Vicki.Wilson@ofm.wa.gov</p> |
| WHERE CAN I READ MORE ABOUT REINSURANCE? | <p>Blumberg, Linda J., and John Holahan. 2004. "Government as Reinsurer: Potential Impacts on Private and Public Spending." <i>Inquiry</i> 41(2): 130-43.</p> <p>Bovbjerg, Randall, and Elliott Wicks. 2005. <i>Building the Roadmap to Coverage: Implementing Government-Funded Reinsurance in the Context of Universal Coverage</i>. Boston: BCBS of Massachusetts Foundation.</p> <p>Bovbjerg, Randall. 2006. <i>Implementing Reinsurance: Health Insurance Reform in Missouri</i>. Project Report 11 under the Missouri Foundation for Health's Cover Missouri Project.</p> <p>Lutzky, Amy, and Randall Bovbjerg. 2003. "The Role of Reinsurance in Medicaid Managed Care." Resource Paper under the Robert Wood Johnson Foundation's Medicaid Managed Care Program. Princeton: Center for Health Care Strategies, Inc.</p> <p>Chollet, Deborah. 2004. "The Role of Reinsurance in State Efforts to Expand Coverage." State Coverage Initiatives issue brief 5, no. 4. Washington, D.C.: AcademyHealth.</p> <p>Cohn, Donald., Enrique Martinez-Vidal, and Deborah Chollet. 2005. "More Answers on Reinsurance." State Coverage Initiatives in focus brief 6, no. 2. Washington, D.C.: AcademyHealth.</p> <p>EP&P Consulting, Inc. 2004. <i>Report on the Healthy New York Program</i>. Prepared for State of New York Insurance Department.</p> <p>Swartz, Katherine. 2005. <i>Reinsuring Health: Why More Middle-Class People are Uninsured and What Government Can Do</i>. New York: Russell Sage Foundation.</p> <p>Swartz, Katherine. 2006. "Reinsurance: How States Can Make Health Coverage More Affordable for Employers and Workers." Commonwealth Fund pub. No. 820. Boston: Harvard University.</p> |